

FILED DEC 27 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. _____
Registrar's No. **10554**

43034

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 10554			
1. PLACE OF DEATH a. COUNTY 7				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Washington					
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis				c. CITY (If outside corporate limits, write RURAL and give township) Belgrade					
d. FULL NAME OF HOSPITAL OR INSTITUTION 4373 West Pine				d. STREET ADDRESS (If rural, give location) Rural					
3. NAME OF DECEASED (Type or Print)		a. (First) James		b. (Middle) S.		c. (Last) Wilson			
4. DATE OF DEATH		(Month) Dec.		(Day) 10,		(Year) 1950			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower		8. DATE OF BIRTH March 6, 1862			
9. AGE (In years last birthday) 88		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.			
13a. FATHER'S NAME Dennis Wilson		13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Josephine					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Gus Aronson ADDRESS 1156 No. Union					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Toxemia ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Decubitus ulcers DUE TO (c) Senility II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 715X					
22. I hereby certify that I attended the deceased from March 1942 , to Dec 10, 1950 , that I last saw the deceased alive on 12-10- , 19 50 , and that death occurred at 6:05a m., from the causes and on the date stated above.									
23a. SIGNATURE Ed. Adlauer (Degree or title) MD		23b. ADDRESS 602 N. Grand St. Louis, Mo		23c. DATE SIGNED 12-11-50					
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-10-50		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) Ironton, Mo.			
DATE REC'D BY LOCAL REG. DEC 11 1950		REGISTRAR'S SIGNATURE J. B. Lusater		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe ADDRESS 4700 Washington Blvd.					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student

Student Embalmer

Signed

Robert M. Murray

Licensed Embalmer No. *3749*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.